



Carlos, D. M., Silva, L. M. P., Beserra, M. A., Aragão, A. D. S., Gregory, A., & Ferriani, M. D. G. C. (2019). Social support network of family members of abused children and adolescents: Perspectives and possibilities. *Journal of Clinical Nursing*, 28(5-6), 814-827. <https://doi.org/10.1111/jocn.14665>

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Social support network of family members of abused children and adolescents: perspectives and possibilities

ABSTRACT

Aims and objectives: Analyse the network of care and social support from the perspectives of family members of children and adolescents who have been abused.

Background: The theoretical-methodological background of the ecological model for understanding violence and the Paradigm of Complexity provide a broad perspective of violence. The paradigm considers all aspects that constitute a phenomenon as well as particular features.

Design: Qualitative research based on the Paradigm of Complexity, which Edgar Morin is the primary philosopher. We have adhered to the COREQ Checklist.
guidelines for qualitative research.

Methods: Data were collected through Minimal Maps of Personal Social Networks and semi-structured interviews held with 15 families who were assisted by a non-governmental organization in a Brazilian city. The notions of comprehension and contextualization guided the data analysis.

Results: Two categories emerged from the data analyses: “Social isolation” and “Affective relationships needs”. The maps revealed a weakened and limited network with low-density, homogeneous bonds and few significant bonds. Therefore, the network provided predominantly instrumental and material social support with few important effective relationships. The participants disclosed some strategies to empower their lives.

Conclusions: We conclude that it is urgent to develop strategies in a broad manner to promote family empowerment, especially on education and employment dimension; to construct supportive and respectful relationships between services and families as well.

Relevance to clinical practice: The present study contributes to international clinical nursing, especially in low- and middle-income countries, by discussing (1) looking at and caring for family members of children and adolescents who have been abused in a contextualized manner; (2) family empowerment, which enables them to have access to healthier environments and to educational/employment opportunities; and (3) broad comprehension of health care among the family members, which provides perspectives not only for looking at violence but also for strengthening supportive social relationships.

SUMMARY BOX

What does this paper contribute to the wider global clinical community?

- Due to its high prevalence around the world, abuse of children and adolescents represents an important issue in health sciences and nursing. Providing care for abused children and adolescents as well as their family members may constitute a significant part of a nurse's role.
- Since most children and adolescents as well as their families access health services at some point, the present study greatly contributes to international clinical nursing by discussing the importance of (1) contextualized care for family members of children and adolescents who have been abused; (2) family empowerment, which enables them to have access to healthier environments and to educational/employment opportunities; (3) a broad comprehension of health care among the family members, which provides perspectives not only for looking at violence but also for strengthening supportive social relationships.

KEYWORDS

Adolescents; Child; Community Care; Domestic Violence; Family-Centred Care; Health Promotion; Public Health Nursing; Qualitative Study; Support Group.

INTRODUCTION

Violence towards children and adolescents remains a serious worldwide problem. Hillis, Mercy, Amobi and Kress (2016) performed a systematic review of population based studies regarding violence against children and found that one billion children and adolescents experienced violence in 2015 in a sample of 96 countries representing more than half of all children and adolescents within the age range of 2 to 17 years. These rates differ dramatically across the world – for 2- to 14-year-olds, the minimum prevalence estimates indicated 31% in Europe, 34% in Latin America, 50% in Africa, 56% in Northern America and 64% in Asia. For 15- to 17- year-olds, the prevalence estimates were 31% in Europe, 33% in Latin America, 40% in Oceania, 48% in Asia, 51% in Africa and 58% in North America. The synthesized findings for the base case scenario showed that 44% and 59% of children were exposed to some violence or severe violence in developed and developing countries, respectively. Therefore, there are children who are much more at risk of violence than others, and, for example, in Europe the prevalence of the more severe types of violence tended to be lower than others regions (Hillis et al. 2016).

The World Health Organization (WHO) defines violence as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation” (World Health Organization 2016). There are four types of violence – physical, sexual, psychological and deprivation or neglect (Violence Prevention Alliance 2014). The present study focuses on interpersonal violence, for example the violence between individuals, in the family context (World Health Organization 2016). The term ‘child abuse’ has been adopted, as recommended by the Medical Subject Headings.

The United Nations International Children's Emergency Fund (UNICEF) reports that six out of every ten children between 2 and 14 years old are victims of physical punishment and

psychological aggression by their family members (UNICEF 2014). In Brazil, accidents and violence, which are combined in mortality estimates, are considered the leading causes of death in children between 1 and 19 years of age (Brasil 2013).

The high rates of abuse of children and adolescents reveal the extent to which violence impacts the lives of these populations. Violence goes beyond physical harm, and its consequences include not only death and injury but also communicable and non-communicable diseases, difficulties in study and work and involvement in crime (World Health Organization 2016).

In fact, many of the consequences of violence affect the health sector and cause an immediate human and economic impact (World Health Organization 2016). A child who has suffered violence is at increased risk of being a victim or perpetrator of sexual, juvenile, self-inflicted and intimate partner violence (Bott, Guedes, Goodwin, & Mendoza 2012, Fulu et al. 2013, World Health Organization 2016).

The WHO has presented some guidelines for dealing with violence against children, adolescents and their families, including: (1) creating safe, healthy and supportive family environments and providing specialized assistance and support to families that are vulnerable to violence; (2) providing access to high-quality services to support children who have suffered violence; and (3) coordinating the actions of multiple sectors that work to prevent and respond to violence against children, adolescents, and their families (World Health Organization 2016). Considering these aspects, and using an ecological approach to comprehend violence, the perspective of the family and its social support network is essential for coping with and preventing child abuse. One study showed that even in parents with a history of child maltreatment, positive social relationships were significantly related to reducing the likelihood of perpetuating violence; and for those without this history, these relationships were not related to subsequent perpetuation (Thornberry et al. 2013).

Two preliminary studies focused on the social networks of abused children and adolescents from the perspectives of Primary Health Care professionals, especially nursing staff (Aragão, Ferriani, Vendruscolo, Souza, & Gomes 2013; Carlos et al. 2017a). Both studies revealed weak and reduced networks in vulnerable environments, with a prevalence of fragmentation and not sharing responsibility for the care provided to the families. These factors are associated with the challenges that professionals face when addressing different violence scenarios, such as reporting cases of violence to the protective network services.

Related to the advances in the scientific literature on the theme of abuse of children and adolescents, and considering the need to broaden the discussion regarding the families and social support networks, this study aimed to explore the network and social support provided to family members of children and adolescents who had experienced abuse. The social support network must be understood as “one piece of a multifaceted strategy” to achieve coping with and prevention of child and adolescent abuse (Spilsbury & Korbin, 2013).

BACKGROUND

Abuse of children/adolescents is a multifaceted problem; this phenomenon is rooted in social, economic, and cultural factors that impact on communities, families, relationships, and the way that children and adolescents experience their daily life. The ecological model for the comprehension of violence, proposed by the WHO, reflects interactions among individuals, relationships, communities, and social factors, and the model represents dimensions in which risks and possibilities for prevention coexist (World Health Organization 2016).

From this epistemic perspective, violence is embedded in different levels; the interaction among the factors at distinct levels is as important as their influence on a single level (Krug, Dahlberg, Mercy, Zwi, & Lozano 2002, World Health Organization 2016). For example, some studies have suggested that common risk factors, such as loosening family ties and low social

cohesion within the community, which are aggravated by humanitarian crises such as armed conflicts, economic migration, natural disasters, and medical emergencies, make children more vulnerable than other demographic groups to all forms of violence (World Health Organization 2016).

It is necessary to develop a broad view on abuse of children / adolescents focused on their family members and context; considering this issue, a social network and social support approach may be appropriate. Social networks are specific resources for social support, while social support exchange is the main aspect of the development and maintenance of social relationships (Latkin & Knowlton 2015). Social support includes emotional, informational, and instrumental support, which refer to a sense of belonging, esteem or valuation, and demonstration of affection and love; facts or advice to help people to solve their problems; and supplemental material assistance to clarify doubts or solve practical issues, respectively (Thoits 2011). A literature review about social support suggests that analysis of social networks may reveal specific aspects of social relationships and their effects on individual welfare and health (Latkin & Knowlton 2015).

The theoretical-methodological basis of the model adopted in this study provides a broad view on violence, unlike more fragmented strategies and approaches that not focus on the context. The Paradigm of Complexity, developed by Edgar Morin, considers all parts that are involved in forming a phenomenon without disregarding the singular characteristics of each part (Morin 2008). The complexity approach can reveal interrelationships that are not possible in compartmentalized approaches. To better understand these issues, it is essential to overcome the traditional laws of order, separability, reduction and logic, exposed by Aristotle, Newton, Descartes and other philosophers of classical science. The complexity paradigm is related to cybernetic and system theories; it aims to articulate some limits of “human understanding in relation to both natural and social phenomena” (Tremblay & Richard, 2011).

The complex-thinking approach seeks connections, relationships, and contradictions that comprise the social context (Morin 2008). Considering these aspects, this paradigm is coherent and enables a comprehension and contextualized view of the singular and plural factors involved in violence. It interacts with the ecological model by considering the context in which the person is included. Therefore, it makes sense to investigate the social support network of the families of abused children and adolescents considering the Paradigm of Complexity in order to help understand the gaps and possibilities for providing care to these families.

METHOD

Study design

This is a qualitative study; this approach involves recognition of the perspectives of participants who are directly involved in a given situation and respects their uniqueness and diversity; and the possibility of making approximations and applying a variety of methods (Flick 2009). As mentioned in the previous section, the theoretical-methodological framework of this study is developed from the Paradigm of Complexity. We have adhered to the COREQ Checklist.

Context and participants in the study

The city Campinas, São Paulo state, Brazil, occupies an area of 796 km² and has a population of 1,144,862 inhabitants distributed across four districts. The region accounts for 10% of the agro-industrial production in the São Paulo State and is ranked highest in the country in terms of agricultural mechanization and use of high-quality seeds. Despite economic development, the social inequality is high with some areas of very high vulnerability.

The study was conducted through a Non-Governmental Organization (NGO), that provides services for cases that have special or medium complexity in the social welfare area. This NGO aims to aid families of abused children and adolescents by improving their rights; preserving and strengthening family, community, and social ties; and strengthening the protective role of families against factors that make them vulnerable to violence. The professionals have been performing social and psychological care. In 2015, the NGO assisted 146 families, which were referred by social assistance services, Guardianship Councils, and Childhood and Juvenile Court.

The study participants were members of nuclear families where children / adolescents had experienced abuse and who were assisted by the NGO and fulfilled the following inclusion criteria: (i) families composed of at least one child or adolescent victim of suspected or confirmed abuse; (ii) families that were assisted by the NGO for at least one year. Exclusion criterion were family members who perpetrated child and/or adolescent abuse. Participants were successively recruited until data saturation occurred. This data saturation is related to the in-depth answer and exploration of the questions. The NGO staff guided the selection of participants who were available to provide information and answer the questions for this study.

The first author collected the data with the participants. Her approach to the participants occurred in an individualised manner, following the NGO staff selection. She explained the objectives and purpose of the study, as well as the ethical aspects. Moreover, she indicated the importance of reflecting on the social network for the family members as a study's short-term benefit.

Data collection

Considering the method used, as well as the notions of contextualization and comprehension, data were collected through the Minimal Maps of the Individual Social

Network (Sluzki 1996), and semi-structured interviews from February to April 2016. The first one was appropriated to contextualize the family members' life and support; and the second one was adequate to problematize and deepen the perceived support.

The first step consisted of constructing the Minimal Maps of the Individual Social Network (Figure 1) with family members using the method reported by Sluzki (1996). These maps characterize the bonds between the participants and formal or informal community groups, sectors, governmental and non-governmental organizations to help identify the existing resources and gaps with the purpose of integrating, strengthening, and optimizing the existing social network.

The maps are represented by concentric circles divided in four quadrants, and the individuals' relationships with family, friends, school/work, communities (e.g., religion, sports, cinema, theatre, clubs, city squares, and others), health services, and social services were arranged in the quadrants. The concentric circles represent the strength of the relationship established between the individual (at the centre of the map) and the sector/institution that was assessed, and the strength levels were intimate, social, or occasional. The quality of the bonds between the individuals and the institutions mapped in the quadrants was classified as significant, weakened and broken/non-existent, and those classifications were represented by solid black lines, dashed black lines, and grey lines, respectively (Sluzki 1996). Therefore, the maps allow researchers to understand how these relationships are established.

The researchers explained the purpose of the study to the family members as well as the meaning of each quadrant and concentric circle and how to construct the maps. The map design was not limited to the quadrants specified by the researcher, and the family members were free to include new institutions and/or sectors based on their own life experiences. The maps were constructed with the participants, in a private room in the NGO. The maps were anonymised; they were printed in a Letter format, from Microsoft Word Office 2010.

The script of the semi-structured interview included two open guiding questions: (1) Who can you count on day to day to help you? (2) What could be done to improve your own life and your family's life? The study reached "thematic saturation" after the fifteenth interview and no new participants were recruited so the deepening of the study questions could be achieved. Considering the Paradigm of Complexity, we conducted our analysis concomitantly with data collection to identify emerging themes. Six of the 15 family members were interviewed in their homes, while the other nine were interviewed in a private room at the NGO. The interviews were held with one member of each family cluster, except for family number 3 in which two members were interviewed.

The history of the family members of abused children and adolescents was analysed to identifying their main characteristics, including age of the children and adolescents; notification date; type of violence suffered; the violence perpetrator(s); use of alcohol and other drugs by the family members; status of the violence at the Judiciary. The participants consented to this information be taken.

The interviews were recorded using a tablet equipped with the Easy Voice Recorder software (Digipom, Montreal, Canada), and the audio files were fully transcribed. Each interview took approximately 15-30 minutes, and the interviews were identified as E1 to E15 in the order in which they were held to guarantee anonymity. The map numbering from 1 to 15 corresponds to the codes of the interviews as well. The participants revised the transcripts of their interviews; the researcher read aloud the transcripts to four of them because they were illiterate. This aspect – some participants are illiterate – did not involve using a different manner to collect data, because the maps construction and interviews were done face to face, in the spoken form. The member-checking is consistent with the Paradigm of Complexity because it guarantees the researcher co-participation and participants in the knowledge construction.

The data were translated from Portuguese to English. Related to maintain the complexities of language, the authors adapted some informal terms to formal language through a dictionary of synonyms. Therefore, a professional editing service translated the speeches.

Data analysis

The data analysis process was guided by the two main notions of the Paradigm of Complexity: contextualization and comprehension. Contextualization is not “amalgamation” or “bonding” of knowledge from different areas, but is a transdisciplinary view of a given phenomenon to comprehend it through multiple dimensions. Comprehension, in turn, refers to understanding the meaning of an object or fact and to analyse it in relation to other objects or facts. The Minimal Maps could direct the contextualization, while the interviews could help to comprehend the social support and possibilities to improve it.

After performing the document search, constructing the minimal maps, and transcribing the interviews, the collected information was classified and organized through attentive reading of the material to identify the main points in the maps and interviews as well as developing their pertinence and relevance for the study participants. The maps were analysed for the following criteria: size (i.e., the number of personal or institutional bonds established and classifying the network as reduced, medium, or extended); density (quality of bonds and classifying the network as significant, weakened, or broken/non-existent); distribution/composition (number of people or institutions in each quadrant, which may identify the network’s fragility and potential); dispersion (geographical distance between the people or institutions and the other sectors); and homo/heterogeneity (diversity and similarity among people and/or institutions that compose the network).

We used the framework approach proposed by Elos and Kynga (2008). We have chosen the inductive way, coherent with the Paradigm of Complexity. As cited above, we conducted our analysis of maps and interviews concomitantly with data collection to identify reference frameworks. These frameworks were explored in subsequent maps and interviews, so the categorization was consistent across data collection.

Initially, the main aspects from interviews were maternal overload; social isolation; health services – welcoming and bonds aspects; physical and mental disorders; social exclusion; reference service's importance; religious beliefs; transgenerational violence; intimate partner violence; lack of prospects. Subsequently, these aspects were articulated to maps analysis; reference frameworks with the main points of the answers from family members were organized to obtain a broad view of the information to categorize it. This organization provided not only a broad view of the data but also highlighted specific issues related to the research theme as a whole.

At this point, the researcher noticed that the references for speeches and maps pointed to three main aspects – social and historical background; social support networks and the potential for strengthening networks – that were identified as reference frameworks. These aspects were articulated in four categories: I did not have; I do not have; Affectivity relationships needs; Social isolation. In this study, the third and fourth categories were discussed; they are considered opposite *a priori*, but related to Complexity Paradigm they are in dialogic process – two principles or notions must be mutually exclusive, but they are present and inseparable in the same situation or phenomenon. Such categorization process is summarized in Chart 1:

Chart 1 – Process of categorization of reference frameworks.

Category	Reference frameworks
Social isolation	Friends as sources of instrumental social support
	Social, health and education services as weakened bond
	Integration into labour marketing
	Education and social integration
Affective relationships needs	Relatives / extended family and neighborhood as sources of emotional social support
	Faith and religious beliefs as social support
	NGO as significant bond
	Synthesis – affective relationships relevance

Finally, we established relationships among the data, the principles of the Paradigm of Complexity, the legal devices, and the scientific literature.

Ethical Considerations

The Institutional Review Board of the University of São Paulo at Ribeirão Preto College of Nursing approved the study protocol on February 3rd, 2016 (protocol CAAE 48671415.0.0000.5393, letter 1.402.405), which complied with Resolution 466/2012 of the National Health Council, Brazilian Ministry of Health. The participants signed the appropriate informed consent form for adults and adolescents. The coordinators of the Municipal Health Department and the non-governmental organization formally agreed to participate in the study. The first author of this study collected data and interviewed the participants in a private and protected room to ensure the confidentiality of information.

RESULTS

In this section, we present the main characteristics of the 15 families assisted by the NGO who participated in this study (Table 1) and the two categories that emerged from data analyses “Social isolation” and “Affective relationships needs”.

In general, one member of each family cluster participated in the study, except for the family E3, for which two members were interviewed. All participants lived in homes with between three and six other people. In 11 families (73.3%), one member was a user of psychoactive drugs; in two families (13.3%), one person had serious mental health difficulties; and in one family (6.7%), one person lived on the streets. Additionally, one family (6.7%) had a member who perpetrated sexual exploitation; one adolescent had broken the law and served a sentence involving socio-educational measures; one female participant served a conditional sentence after being arrested; 11 families had a history of gender violence; and three families experienced intergenerational domestic violence. Regarding the interventions performed with the families: 12 families participated in basic social protection network services; the perpetrator was jailed for one family that experienced sexual violence; four families were involved in the specialized protection network; and the members of two families were already sheltered by protective institutions.

Social isolation

The family members’ maps and interviews revealed a markedly weakened and small network with low-density and homogeneous bonds (Table 2). The Map 1 is used as an example (Figure 2). Consequently, the social support that emerged from this network was mainly instrumental and material with few important affective relationships, demonstrating a social isolation: *It’s just we, and we and God! (E3)*

Friends were important components of the support network for some family members with few but significant bonds that provided emotional and instrumental support, as shown in maps 5 and 7 (Supplementary Figure 1). For some family members, friends represented weakened and/or broken bonds mainly due to associations with drug trafficking and lack of solidarity. These bonds can be seen in maps 3 and 4 (Supplementary Figure 1).

Someone that pats me on my back and talks like “what’s up buddy”, “are you ok?” [...] I don’t want that. I don’t want a false friendship. I just wish for a true friendship [...]. (E1)

Social assistance services were punctual and compensatory, and they mainly provided instrumental social support: *‘You will not receive anything else, it’s just today’ – then I said ‘ok’ [...]. (E3)*

The family members represented health services as weakened bonds and punctual assistance, and they considered them to be “favours”. This form of support is represented by concrete actions, such as consultations, prescriptions, and medications, which are clearly focused on diseases and curative actions. Maps 3 and 5 (Supplementary Figure 1) depict these aspects.

Although schools are a vital service of the protection network for children and adolescents, the family members had weakened bonds with this service and considered many professionals to have an inadequate approach. Most of the maps illustrate these aspects (maps 1, 3, 4, 5, 6, 8, 11, 12, and 15) (Supplementary Figure 1).

A fact of what happened in my life [interviewee experienced violence] is many [school professionals] discriminate by thinking ‘how something like that could happen to her’... (E4)

Related to other services and sectors, the family members are clearly isolated. They established either no or few bonds with other people in most of the sectors, and they had low-density and weakened support networks.

[About the social context] *There is no movement; there is nothing [...]. (E5)*

[About leisure and culture services] *No, I only stay at home. I don't go anywhere. I hardly ever leave here. (E14)*

The family members considered integration into the labour market as an opportunity to have a dignified life; however, the maps and interviews demonstrated that they did not have access to jobs. When they had a job, it was usually precarious or an informal job without stability, which resulted in weak, occasional relationships with colleagues and little money (instrumental support) coming from this source.

He is trying to find a formal job, but it is very difficult to get it [...] there are few job positions available. (E11)

The family members had limited positive future perspectives, considering the historical isolation process they have coped; they often reflected on the global context and the current financial crisis in Brazil:

Sometimes, I have no more dreams (silence) [...]. (E1)

The [financial] crisis is general; there are many big companies that have already dismissed a lot of people— a lot of employees. (E4)

Considering health promotion, in an expanded view, the family members referred to education, participation in social life and access to formal employment as possibilities for improving their vulnerable situation:

The only thing I need is education and to have access to work positions, it's what I want most, but I'm stopped and it's not working well... I'd like something to do, you know? An activity or something (E11)

I would like to have a job not just for the salary, but for the possibility of getting out of the house... Because I have stayed at home too much (...) then I've been sad (...) What I need

is to hang out and know people, not just for dating, understand? To meet friends and talk about things... (E3)

Affective relationships needs

The family members disclose an important aspect to construct significant bonds – establishment of affective relationships between them and other people/services. The family members reported the presence of relatives in their social support network, especially those from their nuclear family, who often lived in the same house and provided not only emotional support but also instrumental social support. In other words, the relatives helped take care of the children, provided housing assistance, and eventually provided financial assistance. Maps 9, 10, and 11 (Supplementary Figure 1) demonstrate such bonds.

Only my children and my husband help me all the time; the other relatives don't ever help me. (E9)

My family is just me and my children. That's it! It's just me and my children. (E10)

But my mother, my sister-in-law [...] they help me with everything [...]. When I do not have things at home, they take things to G and G [children] [...]. I live with my mother, together [...]. (E8)

The words 'just' and 'only' have permeated the speeches; they indicated the absence of other support possibilities, as well as the centrality on nuclear family. Some family members pointed to the presence of extended family in their support network, but the bonds established with them were predominantly weakened or broken, as shown in maps 1-4 (Supplementary Figure 1).

Family, instead of helping me, they just bother me [...] they have their own lives, everyone has his/her own life [...]. (E7)

The neighbourhood community emerged as a significant factor in the networks of family members, as shown in map 8 (Supplementary Figure 1). Although they had not established in-depth affective bonds, they constituted significant sources of instrumental social support through helping with childcare and providing food to families.

She helps me. Sometimes, she gets a temporary job, short-term jobs, or does housekeeping, and I take care of her children [...] I help her, and she helps me, so we combine efforts this way [...]. For example, now I don't have a refrigerator, she said [...] I could use hers [...] because every time that I cooked I had to throw it out because it spoiled [...]. (E7)

The family members also referred to faith and religious beliefs as components of their support network. They referred to “God” and clearly distinguished the deity from the church. These aspects are clear in maps 2 and 9-15 (Supplementary Figure 1):

I feel that God protects me inside the church, but the people's words [...] no. (E1)

Ah, I only trust God. (E9)

The NGO played central roles in the support network by regulating and guiding the routes of interaction between the children and adolescents' family and the network with direct implications for the family's access to other spaces. The social and emotional support provided by these services were considered to be “like a family”.

So, when I feel fragile and I see that I'm going to have a relapse, I am caught by them [...]. (E1)

And when they can't help me, they indicate, you know, what I should do to solve the problem [...] I would be lost if I didn't have them to help me because they guide me [...]. (E3)

In spite of these issues, the family members noticed that some professionals were not prepared to cope with some situations, especially in health, education and social assistance sectors:

It's good, but the coordinators of the health care unit sometimes send a person who is not prepared [...] because to treat depressed people, you must know how to deal with them, because if they feel unsafe, if they feel hurt, the situation will become more complicated [...]. (E2)

To establish significant bonds, the family members wanted a positive welcome, people's attention and listening as well as shared responsibilities.

This little school where the children study, they do judo and people look at me in a nicer way and a more cosy way [...]. (E1)

We can see the child's room, we talk to the teacher [...] I know the person, I trust her [...]. (E11)

Then, he is a physician that I trust and has treated me since I was a child. (E11)

Another possibility for establishing bonds between the family members and support services was a long-term relationship with professionals, which guarantees the continuity of care over time, especially with primary health care staff:

It's difficult, isn't it? One issue is the physician changes all the time [...] every two months, there is a physician change [...] you consult a physician and start the treatment, then another physician comes and changes everything, and you start another treatment again [...]. (E9)

DISCUSSION

This study explored networks and social support from the perspective of families of abused children and adolescents. The two categories "Social isolation" and "Affective relationships needs" showed the dialogic aspect present in contemporary phenomena, such as abuse of child and adolescent, with actuality and future prospects being contradictory, however, complementary to understand social support for family members. Regarding weak and reduced

social support networks for families, the findings corroborate a study that analysed the care networks of families involved in the abuse of children and adolescents from the perspective of Primary Health Care professionals (Carlos et al. 2017a). The social support networks offered by the professionals to provide care to these families were highlighted as reduced, with low-density and non-institutionalized relationships and the emergence of fragmented care (Carlos et al. 2017a). It has been reported in the literature that public health nurses, especially those who work in Primary Health Care, play a central role in welcoming and evaluating vulnerable families, however, they still face challenges in developing multidisciplinary and integrated work (Hanafin 2014, O'Dwyer, Cahalane & Pelican-Kelly 2016, Rossiter et al. 2016).

The networks and reports reveal families are experiencing growing isolation, including from their own relatives. According to Morin (1999, 2008), society is experiencing a contemporary “ethics crisis” associated with a crisis of individual-society-species organization/reconnection. This author states that the subject has a biological basis with its own individual logic that depends on an environment and a society to develop it and become independent. In this study, we found an autonomy-dependency principle with complementary and antagonistic concepts; and it does not seek an absolute freedom that is independent of the living context because independence does not refer only to the physical environment but also to all the relationships among their components and elements/events.

Healthy relationships with domestic violence survivors are not related to who established the bond, but to the quality and strength of the bond (Gregory, Feder, Taket, & Williamsom 2017). The distancing of the so-called "extended" family is relevant because it usually represents affective bonds that can be drawn upon during periods of adversity. Although the informal support is a broader source of social support to cope with domestic violence, scientific studies and support services have neglected it (Radford et al. 2011). The fact that friends were present for the families, however, in small number, helps us to simultaneously

understand the shared risk and protection factors for violence and to develop strategies to prevent multiple forms of violence. Communities where there is low cohesion or trustworthiness, are more likely to have families who experience child maltreatment (Coulton, Crampton, Irwin, Spilsbury & Korbin, 2007) and intimate partner violence (Pinchevsky & Wright, 2012); people who experience social isolation from their family, friends or neighbours are more likely to perpetrate intimate partner violence (Tjaden & Thoennes, 2000) and commit suicide (Crosby, Buckner & Taylor, 2011). Informal social support must be considered within a wider ecological framework, which comprises one piece of a multifaceted strategy to cope with and prevent violence (Spilsbury & Korbin, 2013).

A recent review article about informal supporters for domestic violence and abuse reported that most of the victims feel frightened, threatened, and intimidated by the violence perpetrator, and these feelings directly affect the victims' health and well-being (Gregory et al. 2017a). The violence perpetrators also manipulate, intimidate, harass, and punish the informal supporters of domestic violence survivors (Gregory 2017). Consequently, such supporters suffer from symptoms similar to those who experience domestic violence and note that the presence of children in their own family clusters is a stress factor (Gregory et al. 2017b). In this sense, it is vital to look at the family members and their support network to aid children and adolescents have experienced abuse.

Schools are commonly mentioned in studies because they represent an essential service in the lives of children and adolescents (Horley 2014). School is presented in a dialogic manner (positive *versus* negative) that depends on the actions of certain people, and it means that they develop non-institutionalized actions of fighting against or omission/stimulation of violent attitudes. A qualitative study developed in Connecticut that analysed the factors present in urban violence against young people has reported that some teachers and coordinators attenuated

violent actions by discussing the theme and developing school interventions (Shuval et al. 2012).

The relationships established between the family members and other services included distant and occasional relationships, fragile bonds, and eventual support, especially instrumental. Primary health care professionals from the United Kingdom (Ramsay et al. 2012) and a Brazilian city (Carlos, Pádua, & Ferriani 2017b) were not appropriately prepared to assist the needs of women, children and adolescents involved in domestic violence.

Morin (1999, 2008) indicates there are many potential actions that can occur even during extremely adverse situations in global and local contexts called “cracks” or “alternative deviations”. The families noted some of the possibilities. Schooling and formal jobs were relevant, which corroborated literature reports. The participants strongly associated a high degree of schooling with better job opportunities. The literature shows that lack of economic opportunities and unemployment were correlated with intimate partner violence (Pinchevsky & Wright, 2012); self-directed violence (Reeves, Stuckler, McKee, Gunnell, Chang & Basu, 2012) and youth violence (Wilson, 2011).

An important transversal study conducted in the states of São Paulo and Pernambuco, Brazil, revealed that socioeconomic factors are relative with respect to the occurrence of domestic violence against women from different sociocultural contexts. Up to eight years of schooling is strongly associated with the occurrence of domestic violence, either for the perpetrator or the victim (D’Oliveira et al. 2009). A high degree of schooling is a protective factor against domestic violence, whereas a low degree of schooling is a risk factor for domestic violence (Avanci, Pinto, & Assis 2017).

The current political and economic situation of the studied country is relevant, and it is vital to consider the micro and macrosocial contexts of the families. The current economic crisis and political reorganization strongly impacts people’s lives and corroborates specific studies.

The WHO's ecological model to understand violence (Violence Prevention Alliance 2015) reinforces this idea by considering the relevance of looking at contextual factors that go beyond the family nucleus, and examine factors that are present in the society and community.

The family members' maps and narratives demonstrated the complexity of the phenomenon, and they show where the context unites and is present in all the relationships, elements, and environments. Therefore, it is impractical to analyse such experiences without considering the relationships among all the components and the whole phenomenon, i.e., the influence of the whole over the parts and vice-versa, as well as the connections among the parts. A study conducted with minority urban youth in Connecticut reinforced this issue – perceived feelings of isolation, racism and violence associated to strong parental, neighbourhood and social support absence could impede prosocial attitudes in adolescents and young adults (Shuval et al. 2012).

The family members established close, intimate, and significant bonds with the neighbourhood, which are characterized by emotional and instrumental support. This finding corroborates a literature report that showed parents trusted neighbours to help care for their children when they were absent from their homes, which indicated that collective efficiency emerged as a protective factor (Shuval et al. 2012). Solidarity is considered an essential ethics value in the contemporary world and implicates the reconnection of the individual-society-species circuit to overcome the “ethics emptiness” (Morin 1999, 2008). This issue is essential to public health nurses due to the possibility of developing a community view and joint work to tackle abuse of children/adolescents. A recent Australian study with children and family nurses that discussed care for families with complex needs identified that nurses should acquire knowledge of other areas such as law and community education to work effectively (Rossiter et al. 2016).

The scientific literature points to faith and religious beliefs as important sources of social support in most societies, although this scenario has changed in large parts of Europe (Brewer-Smyth & Koenig 2014; Vander Weele, Balboni, & Koh 2017). The Brazilian culture gives importance to belonging to a religion, including the partner relationships established in this context. The participants of this study considered faith and religious beliefs to be relevant and distinguished from “staying in a religious environment” to “God/superior entity”. Although religion and spirituality are commonly associated with feelings of guiltiness and psychotic or neurotic disorders, and they can also be sources of hope, meaning, peace, and comfort (Brewer-Smyth & Koenig 2014). This discussion is complex and needs to be contextualized; faith-based organizations may be viewed as partners, not as rivals for health services, and these institutions should be better connected to cooperate and concur with each other (Vander Weele et al. 2017).

A support service providing longitudinal care to families involved in domestic violence against children and adolescents is essential (U.S. Department of Health & Human Services 2017). Although they follow and guide the families, their empowerment still represents a challenge because most of the actions are punctual, fragmented, and compensatory, which confirms the lack of programmatic actions guided by public policies. A recent review about social support also indicates that instrumental support may decrease individual efficacy (Latkin & Knowlton 2015). Nursing plays a key role in identifying and reporting decisions related to child protection services (Hanafin 2014). When nurses share their concerns and formulate appropriate responses together with social workers, they help to prevent exposure of children and adolescents to new risks. A systematic multiprofessional analysis provides a solid background to strengthen the decision process, the development of appropriate interventions, and achieving results to children, adolescents, and their families (O'Dwyer, Cahalane & Pelican-Kelly 2016).

In addition to recognizing that services provided material support through tangible actions (such as providing essential food, medical consultations, medicine prescriptions) during discussions, the participants mentioned the importance of bonding, welcoming, sharing responsibility, and all the other actions related to human relations to establish strong bonds with the supporting services. Integral care requires a critical reflection about the ethics and political projects that guide the professionals' actions. Resuming the building of the ethics of solidarity proposed by Morin, the radical defence of the lives of others is extremely strong for putting integrity into practice (Seixas, Merhy, Baduy, & Slomp-Junior 2016). The protective responses should be routinized and automatic, and not for specific professionals and/or services. We should “re-shape community institutions — the settings of everyday life — so that parents continually experienced norms of caring (attentiveness and neighborliness) and inclusion (universality of access to family support; mutuality of respect and caring)” (Melton 2013).

Health professionals should provide skilful and innovative responses to families with complex and varied needs. In addition to attending continuing education classes, nurses also require support and resources for themselves because they play key roles in health care services and the care that they provide to these families can be time-consuming and resource-intensive (Rossiter et al. 2016). Some studies have recommended clinical supervision and debriefing opportunities for nurses and health professionals who continuously assist these families (Hanafin 2014; Rossiter et al. 2016).

The main limitation of this study is that the family members were recruited via a reference service to intervene against domestic violence. Involvement with this service may change the perceptions and experiences of families so that they are different from families who have not been involved with these services. Furthermore, the NGO staff indicated the possible participants, considering the family members' emotional and psychological appraisal. The differences among the family members that participated in the study (whether they were the

violence perpetrators or not) as well as the diversity of violence types also merit specific approaches. For example, studying the violence perpetrators and specifying the type of violence, especially neglect and sexual violence, could open new opportunities for tackling the issue of abuse of children and adolescents.

CONCLUSION

This study demonstrated the weakness of the social networks of family members of abused children and adolescents when they are immersed in vulnerable situations. These networks explain their use of instrumental support of few public promotions and protection services due to the lack of public policies that guarantee their social rights. Although it was expected that this scenario might strengthen the immediate close ties among the participants, the study revealed that bonds among family members and the institutions are fragile. We conclude, therefore, that it is urgent to develop strategies in a broad manner to promote family empowerment, especially on education and employment dimension; in added, to construct supportive and respectful relationships between services and families as well. Additional studies to analyse the relationship between nursing and the child protection network are required.

RELEVANCE TO CLINICAL PRACTICE

Abuse of children and adolescents has emerged as an important theme in the fields of health and nursing due to its high prevalence around the world. Providing care for abused children and adolescents and their family members is a significant part of a nurse's work. Since children, adolescents, and their families look for the health services at some point and nurses occupy a privileged position in assistance, management, teaching, and research, these health professionals are essential agents in this effort.

The present study significantly contributes to clinical nursing from a global perspective by discussing the importance of: (1) looking at and caring for family members of children and adolescents who have been abused in a contextualized manner; (2) family empowerment, which enables them to have access to healthier environments and to educational/employment opportunities; and (3) broad comprehension of health care among the family members, which provides perspectives not only for looking at violence but also for strengthening supportive social relationships.

CONFLICTS OF INTEREST

The authors declare that they have no conflict of interests.

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Table 1. Characteristics of the family clusters of family members of abused children and adolescents.

Code	Participant	Age range (years)	Education	Job	Marital status	Violence suffered by the child/adolescent	Notification year	Denouncer	Victims in the family
E1	Mother	31-40	5 th grade	Unemployed	Married	Neglect	2013	School	4
E2	Father	41-50	4 th grade	Retired	Living common law	Neglect	2011	CRAS	4
E3	Mother	41-50	5 th grade	Unemployed	Separated	Sexual	2005	CREAS	1
E3	Daughter	11-20	High school (finished)	Unemployed	Single	Sexual	2005	CREAS	1
E4	Mother	31-40	8 th grade	Unemployed	Single	Sexual	2013	CREAS	1
E5	Daughter	11-20	High school (finished)	Unemployed	Single	Sexual, physical, psychological, neglect	2007	Hospital	4
E6	Mother	31-40	Illiterate	Unemployed	Living common law	Sexual, neglect	2005	CRAS	3
E7	Mother	21-30	2 nd grade	Unemployed	Separated	Neglect	2010	CRAS	3
E8	Mother	21-30	High school (finished)	Unemployed	Single	Neglect	2009	CREAS	2
E9	Grandmother	51-60	Illiterate	Vegetable seller	Married	Sexual	2007	VIJ	2
E10	Mother	21-30	Illiterate	General services	Married	Sexual	2009	SCFV	1
E11	Daughter	11-20	Elementary school (finished)	Unemployed	Living common law	Sexual	2007	CT	1
E12	Grandmother	61-70	1 st grade	Retired	Single	Neglect	2005	CRAS	2
E13	Aunt	21-30	College (attending)	Receptionist	Single	Neglect	2015	CRAS	1
E14	Mother	41-50	Illiterate	Housekeeper	Married	Physical, psychological	2007	Service network	3
E15	Mother	41-50	5 th grade	Housewife	Married	Neglect, physical, psychological	2005	CRAS	1

Abbreviations: CRAS: Social Assistance Reference Centre; CREAS: Specialized Social Assistance Reference Centre; CT: Guardianship Council; SCFV: Community Centre for Strengthening Bonds; VIJ: Childhood and Juvenile Court.

Table 2. Characteristics of the Minimal Maps of Individual Social Networks of 15 family members of abused children and adolescents, from the supporters' perspective.

Map	Sector / Institution	Quality of the Bond	Strength of the Relationship
1	Family	1 significant / 1 weakened	Intimate / Occasional
	Friends	1 significant / 1 broken-NE	Intimate / Intimate
	School/work	1 weakened	Occasional
2	Community/services	2 significant / 1 weakened / 1 broken-NE	Intimate / Social / Social / Occasional
	Family	1 significant / 1 weakened / 1 broken-NE	Intimate / Intimate / Occasional
	Friends	1 significant / 1 weakened	Intimate / Intimate
	School/work	1 significant	Intimate
3	Community/services	3 significant / 1 broken-NE	Intimate / Social / Social / Social
	Family	1 weakened / 1 broken-NE	Intimate / Occasional
	Friends	1 broken-NE	Social
	School/work	1 broken-NE	Intimate
4	Community/services	1 significant / 1 weakened / 1 broken-NE	Intimate / Social / Social
	Family	1 significant / 1 broken-NE	Intimate / Occasional
	Friends	1 weakened	Social
	School/work	1 weakened	Social
5	Community/services	3 significant / 1 broken-NE	Social
	Family	1 significant / 1 weakened / 1 broken-NE	Intimate / Intimate / Occasional
	Friends	1 significant / 1 broken-NE	Intimate / Social
	School/work	1 broken-NE	Intimate
6	Community/services	1 significant / 1 broken-NE	Social / Occasional
	Family	2 significant / 1 broken-NE	Intimate / Social / Occasional
	Friends	1 weakened	Social
	School/work	1 broken-NE	Intimate
7	Community/services	2 significant / 1 broken-NE	Social / Social / Occasional
	Family	1 broken-NE	Social
	Friends	1 significant	Intimate
	School/work	2 significant / 1 broken-NE	Intimate
8	Community/services	2 weakened	Social
	Family	1 significant / 1 weakened / 1 broken-NE	Intimate / Intimate / Occasional
	Friends	1 significant	Intimate
	School/work	1 broken-NE	Intimate
9	Community/services	2 significant / 2 weakened	Intimate / Social / Social / Social
	Family	1 significant / 1 broken-NE	Intimate / Occasional
	Friends	1 significant	Intimate
	School/work	1 significant	Intimate
10	Community/services	3 significant	Intimate / Social / Social
	Family	2 significant	Intimate / Occasional
	Friends	1 significant	Intimate
	School/work	1 weakened	Social
11	Community/services	3 significant	Intimate / Social / Social
	Family	1 significant / 1 weakened / 1 broken-NE	Intimate / Occasional / Social
	Friends	1 significant	Intimate

	School/work	1 significant / 1 weakened	Intimate
	Community/services	4 significant	Intimate / Social
12	Family	1 significant / 1 weakened / 1 broken-NE	Intimate / Occasional / Intimate
	Friends	1 broken-NE	Social
	School/work	1 broken-NE	Intimate
	Community/services	3 significant / 1 weakened	Intimate / Intimate / Social / Social
13	Family	1 significant / 1 broken-NE	Intimate / Social
	Friends	1 broken-NE	Intimate
	School/work	1 significant	Intimate
	Community/services	2 significant	Intimate / Social
14	Family	1 significant / 2 broken-NE	Intimate / Intimate / Occasional
	Friends	1 significant	Intimate
	School/work	1 weakened / 1 broken-NE	Intimate
	Community/services	2 significant / 1 weakened	Intimate / Social / Social
15	Family	2 significant / 1 weakened	Intimate / Intimate / Social
	Friends	1 broken-NE	Intimate
	School/work	1 broken-NE	Intimate
	Community/services	4 significant / 1 weakened	Intimate / Social / Social / Social / Social

NE: non-existent.

FIGURE CAPTIONS

Figure 1. Minimal Map Model of the Individual Social Network. This map was developed to explain the social networks of the family members of abused children and adolescents from the members' perspectives. The concentric circles represent the strengths of the relationships established between the individual (at the centre of the map) and the sector/institution that was assessed, and the levels include intimate (1), social (2), or occasional (3). Adapted from Sluzki (1996).

Figure 2. Minimal Map of the Individual Social Network of family member #1. The concentric circles represent the strength (intimate, social, occasional) of the relationship established between the individual (at the centre of the map) and the sector/institution assessed within each quadrant (family, friends, school/work, community/services). The quality of the bonds between the individuals and the institutions mapped in the quadrants was classified as significant, weakened and broken/nonexistent, and represented by solid black lines, dashed black lines, and grey lines, respectively.